Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
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Website: http://www.drl.state.wi.us

MEDICAL EXAMINING BOARD

APPLICATION FOR TEMPORARY EDUCATIONAL PERMIT

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK ☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.)

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth _____ month _____ day _____ year

Daytime Telephone Number ( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

School Name: _____ **Location:** _____ (City, State/Country)

Date Diploma: _____ month/day/year **Degree:** _____ **Specialty:** _____

ACCOUNT FOR ALL ACTIVITIES FROM THE DATE OF GRADUATION FROM MEDICAL SCHOOL TO THE PRESENT TIME. MUST INCLUDE PROFESSIONAL AND NONPROFESSIONAL (PERSONAL) ACTIVITIES. ALL TIME MUST BE ACCOUNTED FOR. (Attach additional sheets if necessary)

INTERNSHIPS: HOSPITAL	**LOCATION City, State, & Country**	**BEGINNING DATE mo - yr**	**ENDING DATE mo - yr**
1.			
2.			

RESIDENCIES OR FELLOWSHIPS: (Attach additional sheets if necessary)

NAME OF HOSPITAL OR CLINIC	**LOCATION** (City, State & Country)	**DATES (from - to) mo - yr**
1.		
2.		

PRACTICE	**LOCATION** (City, State & Country)	**DATES (from - to) mo - yr**
1.		
2.		

APPLICATION MUST BE ACCOMPANIED BY:

1. Fee - $10.00
2. Copy of professional diploma & official translation if necessary.

For Receipting Use Only

#564 (Rev. 4/03)
Ch. 448, Stats.

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ECFMG EXAM TAKEN	CERTIFICATE ISSUED	CERTIFICATE NO.	DATE ISSUED
_____ YES _____ NO	_____ YES _____ NO	_____	_____

		YES	NO
1.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
2.	Have you ever failed to pass any state medical board examination, national board examination, USMLE, or FLEX examination? If yes, give details on an attached sheet.	☐	☐
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
4.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
5.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, including status of the charge and the location of court. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
6.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction court, and penalty. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
7.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and, if applicable, list name, address and phone number of your probation or parole officer.	☐	☐
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	☐	☐
9.	Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.	☐	☐
10.	Are you registered, certified or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	☐	☐
11.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	☐	☐
12.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	☐	☐

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For the purposes of questions 12-18 n, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
13.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☐
14.	Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☐
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	☐	☐
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	☐	☐
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	☐	☐
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐	☐
19.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	☐	☐

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AFFIDAVIT OF APPLICANT
(Sign and date <u>in the presence of</u> a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

S E A L

_____
Date Commission Expires

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name Middle Initial Last Name

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.